WORKERS' COMPENSATION INDUSTRIAL COUNCIL

SEPTEMBER 8, 2016

Minutes of the meeting of the Workers' Compensation Industrial Council held on Thursday, September 8, 2016, at 1:00 p.m., Offices of the West Virginia Insurance Commissioner, 900 Pennsylvania Avenue, Room 912, Charleston, West Virginia.

Industrial Council Members Present:
Bill Dean, Chairman
Kent Hartsog, Vice-Chairman
James Dissen (via telephone)
Dan Marshall
Delegate Steve Westfall
Delegate Mick Bates

1. **Call to Order**

Chairman Bill Dean called the meeting to order at 1:00 p.m.

2. **Approval of Minutes**

Chairman Bill Dean: The minutes of the previous meeting were sent out. Did everybody have a chance to look them over? Is there a motion for approval?

Kent Hartsog: Move to accept.

Dan Marshall: Second.

Chairman Dean: A motion has been made and seconded to accept the July 21, 2016 minutes as stated. Question on the motion? All in favor, "aye." All opposed? The ayes have it.

3. **Office of Judges' Report – Rebecca Roush, Chief Administrative Law Judge**

Judge Rebecca Roush: Good afternoon. I tendered this report to you this morning by e-mail. Hopefully you all received it. I don't think there is really anything new in this report to share with you. The statistics look as you would expect them to. The Old Fund is on the

decline, and they make up about 6.17% of the protests in our office or 140 actual protests in the year 2016. Private carriers make up 74.21% or 1,683 protests. Self-Insured employers make up 19.62% or 445 protests.

I know you have a presentation scheduled today so I will be quick, unless you have any questions. I wanted to point out that we just received news that our ALJ position will be approved to be posted within the next few weeks. If you know any good lawyers out there that would like a position in the Office of Judges – experienced in workers' compensation – you might tell them to look for our posting. I'll be happy to take any questions.

Chairman Dean: Mr. Marshall, any questions today?

Dan Marshall: No, Mr. Chairman.

Chairman Dean: Mr. Hartsog?

Kent Hartsog: No questions.

Chairman Dean: Delegate Westfall?

Delegate Steve Westfall: No, sir.

Chairman Dean: Delegate Bates?

Delegate Mick Bates: No.

Chairman Dean: Mr. Dissen, do you have any questions for Judge Roush?

James Dissen: No, sir.

Chairman Dean: Judge Roush, I would like to present you with something for your employees. Back in May the Industrial Council passed a Resolution to honor and recognize "Employee Appreciation Week," May 2, 2016 through May 6, 2016, for the Office of Judges, and the Offices of the West Virginia Insurance Commissioner. I'd like to give this to you to take back to your office and show your employees that we appreciate them.

Judge Roush: Oh, my goodness. This is so special. Thank you so much. They will love this very, very much. I am truly touched. Thank you on behalf of all of them. They really do such hard work, and I am very grateful. Thank you so much!

Chairman Dean: You are very welcome, and thank them for us.

Judge Roush: Thank you.

4. General Public Comments

Chairman Dean: Does anybody from the general public have a comment they would like to make today? [No comments.]

5. Old Business

Chairman Dean: We'll move onto old business. We have a guest here today, Mr. Mark Hooker.

Andrew Pauley, General Counsel, OIC: Mr. Chairman, the continuing series that we are having explaining what we do at the Insurance Commissioner's Office, pursuant to a request by the Council, today we have Mark Hooker. He is very qualified as Chief Market Conduct Examiner for the job. He has training and experience in multiple lines of insurance. He examines companies for us; oversees the examination of companies; outside vendors that assist us; and he has his own in-house staff who are quite credentialed as well. Mark is an active participant in National Association of Insurance Commissioners. In fact, he was former president of the Insurance Regulatory Examiners Society, which is a national organization. He is a national presence, and is probably one of the most qualified Market Conduct Examiners in the nation. With that, I'll let Mark tell you what he does.

OIC Market Examination and Analysis Process

Mark Hooker, Chief Market Conduct Examiner, OIC: Thanks, Andrew. Mr. Chairman, Vice-Chairman Mr. Hartsog, Mr. Dissen, Delegate Westfall, and Delegate Bates, my name is Mark Hooker and I'm the Chief Market Conduct Examiner for West Virginia. I'm going to talk a little bit about who we are, what we do, and about what our processes are. We are going to talk about our mission, some of the key functions, and the analysis and examination function as it pertains to workers' compensation specifically in general terms. If we have time at the end I'll go over some of the compliance issues that we've uncovered.

Our mission is to assist the Commissioner in proactively protecting West Virginia consumers by identifying non-compliant business practices of regulated entities through examinations and data analysis. I want to add a little bit of emphasis on "business practices."

There are other units within the agency that focus on single instances. Our mission is essentially to identify what is a "practice" either by numerical reason or in some cases the severity of the issue.

We're part of the Legal Division and Regulatory Compliance. The unit is basically composed of myself; two market conduct analysts – one with an emphasis on property and casualty, and that would include workers' compensation, the other on life, accident and health. I have four in-house market conduct examiners. By virtue of the fact that we're small we really can't afford to specialize, so there is a lot of cross-training. Having said that, two of them are mostly dedicated to P & C, and two are mostly dedicated to the health side of the business. There is a big crossover area which is workers' compensation. We all get involved in that. I have an administrative support person who helps try to keep me organized, which is very challenging. We employ contractors as necessary. Usually we get a contractor when we require some bit of expertise that we don't have in-house, or sometimes the schedule just doesn't permit doing it with our own staff.

Because we have to do such a myriad of activities we emphasize professional training. When we hire a market conduct examiner, during the first year I require them to get the Market Conduct Management Designation from IRES (Insurance Regulatory Examiners Society), which is kind of basic training on how to conduct an examination. Because of our emphasis on workers' compensation, when funds are available and when scheduling permits, each examiner [within in the first year] is required to go to the Certified Workers' Compensation Professional Training, which is run by Michigan State University. And that's a fairly comprehensive program with a large emphasis on medical management and claims activity. It's a one week course, and it's totally devoted to workers' compensation.

We also require each examiner and analyst to earn the Certified Insurance Examiner Designation or Accredited Insurance Examiner Designation from IRES. This is a fairly robust curriculum. Each of these designations require about eight to ten college level [some people say graduate level] courses in insurance on a major line of business. On the property and casualty side they come from mostly the CPCU (The Institutes), and on the life it's either from LOMA (Life Office Management Association) or the American College. The expectation is that they would earn the lower designation, the AIE, in about three to four years. It's a long training process.

As Andrew alluded to earlier, within the unit we have three certified insurance examiners, one accredited insurance examiner, three CPCU's, and four certified workers' compensation professionals. And everyone has the market conduct management designation. There is a whole host of others that we could go into.

We conduct examinations and analyses on all lines of business, not just workers' compensation. Insurance companies' examinations include the following areas in addition to claims, and that would be: underwriting and rating, producer licensing, policyholder services, complaints and grievances. In the case of health entities we also get into utilization review and quality assurance. It's quite a broad knowledge that they have to have.

In addition to that, of about 98 Articles in Chapter 33, all of about 12 are pertinent to our functions. So the examiners have to be familiar with those aspects. In addition, there are over 90 rules in Title 114 of the Insurance Code. We've got to have knowledge of all but about ten of them. And that's in addition to the pertinent parts of Chapter 23 and Title 85. If that weren't enough, there are insurance related items throughout the Code. In the DMV Code we have financial responsibility laws that we have to have some familiarity with. The AG has some regulations on crash parts when we get into auto. In addition to that, there are some federal regulations. . .the elephant in the room being the ACA that we have to have some familiarity with. In fact, we are in the process of. . .either have conducted or are conducting three examinations related to health care; HIPPA and various other federal regulations.

We also interact with just about all the agency functional areas, and that would include: Rates and Forms, Producer Licensing, Financial Conditions, and Consumer Services. So, we kind of have to be "jacks of all trades." In addition to that, there is a myriad of software. I have 21 passwords right now, and that is the expectation of what the examiners have to have.

I want to put some context to the workers' compensation activity of what we do. As you can see, in the 2015 direct premiums – and this comes from our financial statement data – the entire insurance market is about $9.2 billion dollars. Workers' compensation premiums account for about 3% of that or $300 million. That would not include for the most part self-insureds.

The complaint activity – and these are insurance carrier complaints. Complaints on workers' compensation amount to about 13% of the complaints we get. Workers' compensation is not the most heavily complained about line of business. I don't know if anybody would venture to guess which ones are right now.

Delegate Steve Westfall: P and C business.

Mr. Hooker: Well, actually private passenger auto is number two. The biggest complaint activity we have right now – as far as the insurance market goes – is on individual health. As you may have read in the newspaper, you can understand why. There are issues

with the exchanges, etc. That is our most frequently complained about line of business. Workers' compensation collectively – even if you add in the self-insured and the Old Fund complaints – are just under what private passenger auto is right now. It's about 270 total; about 181 on private carriers.

Delegate Mick Bates: What percentage is the general health market?

Mr. Hooker: Individual health is 366 out of 1,208 complaints. There's about another, if I remember, 120 or so. . .

Delegate Bates: These complaints are primarily consumers. . .individuals that are covered under these plans as opposed to. . .provider complaints?

Mr. Hooker: That would include provider complaints. The Consumer Service Division, which you will get briefed on later down the road, handles those. Sometimes it includes inquiries from elected officials as well.

Delegate Bates: Thank you.

Mr. Hooker: We'll go onto the market conduct analysis process as it relates between what an insurer and a self-insurer would do. It is one of our primary functions. And the basic difference between what we call the "analysis process" and the "examination process" is that we're using data we already have. What we're trying to do is to determine. . .it's a predictive process trying to determine where to focus our regulatory needs. In other words, we're looking at information that we get on financial statements, complaint data, and other data. We are trying to determine whether or not there is an inference of a market failure. In fact, companies do not know when we are doing the analysis process. We don't send a request for any data. This is something that is just done as a course of business. This whole process, including the work product, is completely confidential. As I said, we are looking for an indicator of a market failure. Because all things point in that direction it does not necessarily mean that there is a market failure, but it does help us focus our resources on that.

Again, I'm going to put kind of a context in the workers' compensation market since there is no real market share per se. We related between self-insurer and private carrier in terms of new claims filed every year. Last year roughly 30,000 new claims were filed; about 10% of those were self-insured. When you relate that and break that down around two-thirds of the complaints are on private carriers; about 20% on self-insurers. So, if you relate that to the previous slide, it's about twice as much frequency on self-insurers as it is on private carriers. I don't want to draw too much inference from that, and one of the reasons is that the

private market didn't open up until July of 2005. Most of you are familiar that workers' compensation is a long-tail coverage. In other words, a claim activity might be on file in excess of 20 years. With respect to a self-insured employer, we could receive complaints on a claim that actually had a date of injury in the 90's. That won't happen on a private carrier because there wasn't any around prior to July of 2005. I think Judge Roush presented some similar statistics with respect to the number of protests.

Again, what our purpose is in the analysis process is to identify potential market failures; to determine the need for regulatory action. I want to add emphasis [it's stated that we already have] the work product is confidential. The insurance side of the house, we have two levels of analysis, and the information is shared with other jurisdictions. In other words, we have a NAIC sponsored review system which will actually share our analysis results with other states. The idea behind that is we can collaborate when it is appropriate if two or three states or more are seeing a similar issue on a carrier, and each one of us does not necessarily have to do an examination, but we can work together on it.

I mentioned there are two levels of analysis on insurance carriers. There is a Level 1 process, which there are 15 broad questions covering various categories. Certain financial ratios. . .one that is very pertinent. It's the amount that carriers are expending on defense costs when it is related to premium. If one carrier is spending more on defense costs than the norm, then they may – and I say "may" – they may take a more aggressive posture to claims. We will also look at examinations that other jurisdictions have conducted and other regulatory actions that they have done. There is also summary data provided to us on certain lines of business in the Market Conduct Annual Statement. Again, that's confidential to jurisdictions. What it is it provides data like the number of denied claims as it relates to the number of claims open; the number of cancellations that a carrier is doing as that relates to the amount of policies they have in force; the number of non-renewals; and that type of data. It's a comparative analysis, and we'll look and see how far one carrier deviates from what is the norm that year. We can also do trending from one year to the next. There are certain anomalies like, for example, you are going to see a higher claim activity when we had Super Storm Sandy. There was a lot more claim activity, and we have to take that into context. Right now we get that kind of data on private passenger auto, homeowners, life insurance, annuities, and long-term care. If you noticed, I didn't mention workers' compensation or health. With workers' compensation we don't really have that much of a need for it because we try to leverage the data it has already imported to the claims index through EDI. There is no reason to have carriers report that to us. With respect to health, we will be getting data on major medical. . .major medical for lack of a better word. I think the politically correct term is now minimum essential coverage. West Virginia was a big part of getting that national project under NAIC. We will start getting that data in 2018.

Delegate Bates: Excuse me. . .did the market conduct annual statement. . .that does exist for workers' compensation lines. . .

Mr. Hooker: It does not.

Delegate Bates: It does not exist.

Mr. Hooker: The claims index, we are able to take the raw data and put that into a similar summary report with respect to claims. We could probably – and there has not been much of an issue with it – we can probably get some similar reports from NCCI with respect to cancellations and that type of thing. On the complaint activity we haven't seen that as a problem right now. Actually it's more robust on workers' compensation. . .that kind of goes through the Level 1 process. Once we're done with that there is a decision on whether or not we need to look any further at a carrier.

If we decide we need to take a further look, there is a Level 2 process. And that is more of a free form higher intensity review. While we look at similar areas in the Level 1 process, we also looked at complaints, exams, and regulatory actions. We'll look at the underlying orders or the examination reports or the specific complaint in the Level 2 process. Whereas in the Level 1 process we were looking at high level reasons and dispositions. Does that make any sense to anybody? Also, depending on the nature of the activity, we may look at rate filings, any fluctuating levels in producer licensing, various legal information, certain financial analysis results, and voluntary accreditation programs. Primarily we're talking about NCQA and URAC.

Mr. Hartsog: In total, how many Level 2 reviews would you say you guys do in a year?

Mr. Hooker: Around 27. On Level 1 we're doing about 80. You kind of think of it as a funnel process.

Mr. Hartsog: And how many of those 27 usually lead to some sort of regulatory action?

Mr. Hooker: Well, on a formal regulatory action probably about five or six. We also have kind of an in between type process. We may send an inquiry. . .an official letter. . .that type of thing.

Mr. Marshall: Let me ask you this. On your Level 2, how does that break down as to type of carrier?

Mr. Hooker: It's a broad range. . .probably on workers' comp carriers we did about five last year. We do more than any other jurisdiction. One of the reasons. . .the (West Virginia) Insurance Commissioner's Office has total authority over the workers' compensation line of business. Whereas in other states, on the claims end, it is usually the Department of Labor or some similar organization that has authority over claims. Insurance departments do have some jurisdiction, but it is generally a secondary jurisdiction in that regard. The larger percentages is going to be on private passenger auto, homeowners, and health. We try to do a Level 1 on all of our domestics every year. There is always a caveat. We have a few smaller mutuals that do not follow the NAIC annual statements. It is difficult to do one on them. Also, their collected market shares is less than a million dollars in premium. Unless there is a huge amount of complaint activity, which we haven't seen, we don't see any reason to expend those types of resources on that.

As part of the analysis process on carriers and workers' comp, we also look at some areas that are different in other states. We get [through EDI] the number of claims reported, and we relate that to the number of protests and decisions by carrier issued by the Office of Judges, and also the decisions that are reversed by the Office of Judges. I am going to give a shout-out to Judge Roush for providing us that data. And that gives us a much more thorough review on the workers' compensation side of the house on that because we just don't have that litigation information available on many of the other lines of business.

We also proactively review the "failure to timely act" referrals that are sent to our Legal Division from the OOJ. We will incorporate that into the review. Other information that is frequently referenced – our examinations. In the last couple of years on workers' compensation claims, other than us, I can only think of one jurisdiction that has done an examination focused entirely on workers' compensation claims. We happen to be on the same carrier on that one.

With respect to the self-insurers the process is very similar. On the previous slide we looked at claims; protested decisions issued by the Office of Judges; protested decisions reversed as it relates to the number of claims; complaints from our Consumer Service Division; and failure to timely act. We developed kind of a matrix on all of these categories, and they are rated from one to three; three being the worst number; and we basically add those assessments up, and come up with a risk profile. Unfortunately the slide is too small to see the numbers, but this is an example of a self-insured company and gave it a low risk profile. The components. . .they had a lower than average protested rate; they had a lower than average reversed decision rate; they had no complaints with our Consumer Service Division; and there were no Failure to Timely Act Petitions. When you contrast that, this was a medium to high risk. In that case their reversal rate was almost twice the average of the typical self-insurer. Their protests were about one and a half times the average. There was

a Failure to Timely Act Petition on this, and there was at least one consumer complaint. When you're talking about failure to timely act and consumer complaints, especially on the self-insured side, there is not enough data to make it really credible because we are talking in numbers of one's or two's because there is just not that many complaints. It has been our experience, that if there has been one issue they were likely to find the problem more frequent than what's reported to the Commissioner. The claimant has to jump through some hoops to make a complaint. I'm talking about a written expression of a grievance. It's not just a phone call. The failure to timely act process, nine times out of ten, ten is going to involve an attorney as well. That's the profile. We produce one of these on every self-insurer every year, and share that information with Angie [Shepherd]. We put this all together and look at the entire range of the active self-insured employers and determine what the priorities would be on that.

The next thing I want to talk about is examinations, and what the commonalities are from insurer to self-insurer. In each case the process is confidential until the Order is executed. The fact that we are examining one of these entities we keep that confidential. We are going to give each regulating entity a minimum of 60 days' notice. We do have the authority to give less notice if we think there is a serious issue that has to be dealt with. What I'm talking about is something time sensitive, an allegation of abuse or some type of fraud. Fortunately, we haven't had to do that yet.

With the notice we send a preliminary request packet. What that does it provides the examining entity some coordinating instructions. We are going to have a data request along with that which will get all the claims that have happened during the examining period; all the policies that were issued; also policies and procedures. We want to review what their regulated policies and procedures are before we proceed with the examination process. We generally ask them to return that to us within 30 days. We're fairly flexible on the response times. We express a preference to do the examination remotely. So, if the actual regulated entity can give us access to their systems then we'll do it from the office in order to avoid expenses to the state. Just hotels (and per diem) amount to about $150.00 a day per person. We want to try to control those costs where we can.

The entire process from the perspective of the regulator and the examinee is fairly transparent. If we identify an issue, we're going to send what is called "a request for information," or the vernacular is a "criticism" in that particular instance, and we'll give them time to respond to it. If we accept the response, then that, of course, would not appear in the examination report. If we're at issue with their response it may appear in the examination report. Once we've tabulated all of those criticisms we'll draft a report and do an exit conference. During that point we are still on a confidential portion of the process, but we'll iron out any differences we may have on facts or any differences. . .maybe some massaging

of the language might be necessary at that point. And once that is concluded, we submit a verified report to the Commissioner through our Legal Division, which generally prepares a Consent Order that is sent to the company, and they will have an opportunity to sign. There may or may not be fines or corrective action ordered at that point. There is a rebuttal period. If we were not able to resolve any issues during the draft report/exit conference portion of the exam, the company may make official rebuttals. Those official rebuttals are included with the order adopting the report. The order, the official rebuttals, and the examination report itself from that point is public record. The Commissioner has the ability to hold them confidential for a short period of time, but generally from that point forward they are public record. On insurance carriers we actually publish our exam reports on the website. For self-insurers we do not. The primary difference in that is self-insurers are in the business of delivering packages or doing something other than the business of insurance. The workers' compensation function is an ancillary function to their mission, so we do not publish them on the website. However, should somebody request them through the Freedom of Information Act they are available.

The authority for market conduct examinations is in W. Va. Code § 33-2-9. It basically states: "The Commissioner will examine all domestic entities once every five years." The domestic entities would be the ones that are actually incorporated within West Virginia. Whereas a non-domestic company [in insurance lingo] is a carrier like State Farm, which is actually domiciled or incorporated in another state. However, we do have the ability to accept reports and examinations from other jurisdictions, and of course there is a collaborative examination process.

The insurer examinations are basically governed by standards set forth in the NAIC Market Regulation Handbook, which has general procedures and also specific items by line of business. Having said that, we do generally have to modify the standards so they fit with state law. For example, there may be a NAIC standard that claims are paid in accordance with policy provisions or investigations are initiated timely. In West Virginia, on the casualty side, it is generally a 15 working day period when they have to begin an investigation. That timeframe might vary from state to state. We follow the principles and the standards within the NAIC Market Regulation Handbook, but we make sure they reflect what the actual state requirement is.

There is anywhere between 40 and 120 some standards that we have to do on an insurance carrier, depending on the scope of the examination, and the type of the examination. As far as our domestics, in recent years we have conducted examinations on farm mutual, fire insurance companies. We have a couple of auto insurance carriers in the state; medical professional liability carrier; and workers' compensation. Again, the health entities as well. About 80% of our health insurance market is from domestic carriers;

primarily we're talking about a couple of HMO's, and Blue Cross and Blue Shield. While there are similar regulations within P and C, there is slightly nuance requirements from one type of entity to another.

On non-domestics we primarily do a targeted examination. In other words, we've needed a reason from analysis to go in there. In the last couple of years we've done a couple of examinations on foreign workers' compensation carriers. A large part of our activity relates to third party unfair trade practices. There has been a tendency on general liability carriers and on private passenger auto. We've also done a life insurance exam, which we collaborated with Kentucky and Virginia. We participate in a large amount of multi-state examinations. In a few cases we've been one of the lead states, and in certain cases we've been sort of a participant in that process.

With respect to the self-insurance, the authority is the same. It goes from W. Va. Code § 33-2-9. West Virginia Code § 33-2-21 clarifies that the Commissioner has that same level of authority on workers' compensation.

Rule 18 has some specific items, and it basically says, "The Commissioner shall review claims records of the employer on an annual basis or more frequently as the Commissioner determines in his or her sole discretion to be necessary." We take that to mean that the analysis process that we do on all active self-insureds fulfills that requirement, yet we also want to do at least one physical examination on a carrier every five years. We reserve the right to do it more frequently if the analysis indicates it.

On the self-insured examinations, there is basically 28 attributes that we test. There are some sub attributes within those. But our primary concerns are timely rulings, timely and accurate payment of indemnity, disclosures, complaint handling. The one thing we do not have any tolerance for is an inappropriate response to an OOJ, Board of Review or Supreme Court Order, and that is under W. Va. Code § 85-1-10.7. It is a requirement to respond to that Order within 30 days or within 15 days in certain circumstances.

Other categories we look at are documentation, claims denials. We are very careful in our denial review. We're looking for appropriate denial notices and at least a legal reason for denial. We don't want to interfere with the employer's right to litigate or contest a claim. But certain times we've seen notices where the reasons weren't quite legal. For instance, we've seen denial notices where they were denied for untimely filing, yet the filing of that claim was well within the statute of limitations. You can consider that in a denial, but solely denying it based on the time filing is not acceptable.

We also look at EDI basically for the assurance that the claims index is appropriately populated. There is not a lot of claimant impact on EDI. It generally doesn't interfere with the process in the claims. As you can see, we base our analysis on what is submitted to the claims index. And carriers may look and presume there is a prior injury when there is not if the EDI or the claims index is not populated correctly.

This is a compliance table that is included as part of an examination report to the self-insured carrier. On a high level it will show the number of files we reviewed, the number that passed, and the number that failed, and there will be a percentage passing rate. The examiners also will mark whether or not they feel like that issue requires individual file corrective action or some kind of systemic corrective action. In other words, they've identified some type of business practice on that.

These [next slide] are a couple of recommendations that appeared on that examination report. I am going to highlight a couple. We recommended that the employer advise the claimant of a right to a permanent total disability evaluation at the conclusion of TTD. We recommended that the employer properly state and use a legal basis for denial on its claims. We had some EDI issues. I mentioned before we had 28 attributes in a "catchall." This is one of those "catchalls." What we found was the employer improperly told the claimant there was no physical therapy available. There didn't appear to be any medical basis for that. We cited them on that.

The activity that we've had on self-insured exams during 2014. . .we completed 17, and when I say "completed" that means the Order is adopted and the corrective action plan is submitted. In 2015 it was 21, and 2016 year-to-date we finished 12, and we have eight pending adoption, and four scheduled. The goal is to complete one on each employer every five years.

The next couple of slides just show some compliance errors in the examination process. One being failure to send notice of the right to a permanent partial disability evaluation; failure to send TTD closure letters; improper language on TTD closure letter; failure to send suspension letters; timely rulings; failure to issue ruling letters on compensability decisions. We cited them for that. Also, there were some instances where they issued ruling letters but didn't include the protest clause, which is an important disclosure if you are going to litigate a claim.

On denials we've had late rulings. We've had some documentation issues and I went over one of the examples. The most prevalent issue that we found – and again that's not necessarily reflective of claims handling – it's been EDI reporting.

That is what I had to present today. We have a broad mission in the Market Conduct Unit. We do more than workers' comp. Given the resources and the parameters, we do an effective job. We've had some successes, but I'd like to highlight. . .in the last several years through our examinations and multi-state examinations, we've gotten over $21 million dollars in restitution from insurance carrier examinations and even in the self-insured process. In the last couple of years we've gotten $150,000.00 in restitution for the policy holders. It's a good job. For the most part I really like what I'm doing, and I'm fortunate to have a good staff to work with. If there are any questions I'll be happy to entertain them.

Chairman Dean: Mr. Marshall, any questions?

Mr. Marshall: Yes. I'd be interested to know how many domestic companies for which there is a primary regulator, and what the breakdown as far as categories of those companies would be – West Virginia domicile companies.

Mr. Hooker: I think in the last count we have around 28 domestics. With all of the BrickStreet companies there is three or four. . .there is about three on workers' compensation, one med mal. . .we have five health carriers, and the remainder of those are small P and C companies. The farm mutual fire insurance companies, and a couple that do automobile insurance; we have one non-standard auto in the northern part of the state; and automobile insurance company that is domiciled in the eastern panhandle.

Mr. Marshall: No life companies?

Mr. Hooker: No life companies right now. We have one that technically is a life company because they file their annual statement on the "life annual statement form," but it's really a health. They primary do point of service for HMO entity and a PPO product.

Mr. Marshall: Thank you.

Chairman Dean: Mr. Hartsog, do you have any questions?

Mr. Hartsog: One two-part question. With workers' comp, what do you see as the major compliance issues that you deal with year to year? And part two of that question is does any of that cause you to say, "Well, we need something additional or a modification to the rules to kick around to help with compliance issues."

Mr. Hooker: For the first part there are a couple of things. This is anecdotally. . . through TPA's and carriers who do not have a presence in West Virginia. I mentioned earlier ruling letters. If they're issuing a ruling letter, it is defective in some kind of way. That is a big

one. We've also seen instances of tolling that may continue. Rule 1 does not have a specific limit on tolling. On the casualty side, if you have not closed that claim within 30 days you have to start issuing what is called "a notice of necessary delay." You have to continue issuing that letter until the claim is closed. I don't think in Rule 1 there is actually a tolling letter requirement, but we do look at that as evidence that they are gathering more information. I think that certainly the TPA's and the carriers that have a presence within the state are more familiar with the idiosyncrasies of our rules. Did that answer it?

Mr. Hartsog: Yes. The problems that you run into are addressed in the rules, and you have what you need to address noncompliance with the exception of possibly this one area on tolling and being specific date wise.

Mr. Hooker: Yes. I'd say that's a fair statement. There is probably a couple of things I'd like to see. I'm not necessarily sure that a regulation is the panacea for it.

Mr. Hartsog: Well, I'm not real big on that unless there is an issue that really does need to be addressed.

Mr. Hooker: Again, those are a couple of things we have observed. For the most part, I had a slide on complaints, and I think Judge Roush has made several presentations on protests. The number of complaints are way down. We have about a third of the complaints that we had in 2008 when the market opened. I think that speaks well that things are getting better.

Mr. Hartsog: As the Chairman stated when he started the meeting we only have two people from the general public attending these meetings routinely. Unless there is something stirred up there is usually not much attendance at these meetings, which I think is a good sign that things are going well because that's what we'd be listening to are people complaining if it wasn't going well. I would like to hear Andrew [at the next meeting] talk about tolling, and see if you think anything needs to be updated.

Mr. Pauley: Well, there is the FTA process, and that has been fairly successful, and I think the Office of Judges did a good job. You can't define in the rules every single time period for every single thing.

Mr. Hartsog: No, you cannot.

Mr. Pauley: I think the Office of Judges did a good job of parsing out when it may be a gray area. For instance, three months was just too long to act on this, or six months was too long, or a year was too long. The definition of acting on a claim is broad for a particular

reason. We have self-insured employers; we have insurance carriers; a lot of different people. I believe by and large, frankly, the FTA process is catching most of those. Then that creates an Order from the Commissioner that Mark eventually does analysis on, and that is one of his triggers when he sees FTA's that are coming down on carriers. I can see your point. We'll be happy to give you additional comments. But I think from that standpoint that mechanism is there, which is somewhat different from the insurer's perspective, which we're looking more for consumer complaints. As Mark mentioned, there is the Notice of Necessary Delay in the need to keep one apprised of a claim. Don't leave a claim hanging out there in workers' compensation. Let the person know where it's at in any particular stage of that claim. When they've waited too long, there's the Failure to Timely Act process which allows the person to say, "This is taking too long for them to act on my claim." Of course, they can come in and vindicate themselves and say, "No, wait a minute. This is why we did this. We were waiting on something from your doctor, etc." But on the other hand, the Office of Judges may look at it and say, "No, this is just too long. You can't justify why you took this long. You left this person hanging." And then that goes to the Commissioner for additional compliance. There is individual compliance for FTA's. Mark is more of the macro person. We have the micro investigations and compliance, but Mark is always looking at the macro. He is looking at the bigger picture. If a particular company or self-insured employers get two or three FTA's in a short period of time, he is going to know about that through his analysis. I think that is where we are going to address that situation, if it's an acute situation. If it's an annual analysis or some other type of thing, he is going to look back and say, "What did they do the last time? Have they've gotten better?"

Mr. Hartsog: I'm very good with. . .things are okay with what we have, if that's the answer.

Mr. Hooker: I do want to echo what Andrew said about the Office of Judges' Fairly to Timely Act decisions. They've basically taken a position on it.

Mr. Hartsog: Is there more clarity needed to keep it out of the Office of Judges so they will have a better definition as to when they would need to act, or is that just best left to judgment and to the Office of Judges?

Mr. Hooker: Well, I will say this. I think there is clarity, and a ruling needs to be done within 15 working days. What we do. . from an enforcement perspective. . .we need to emphasize that that is the minimum standard. That is not the goal. If it can be done quicker, then it needs to be done quicker. Sometimes the minimum standards and the goal get confused. I'm going to have to defer to Andrew on that. We have seen FTA orders that we said, "Okay, although it is not clearly specified this is entirely too long."

Mr. Hartsog: Thank you.

Chairman Dean: Delegate Westfall, do you have any questions?

Delegate Westfall: No, sir.

Chairman Dean: Delegate Bates?

Delegate Bates: Thank you for the presentation. It gives me a much better understanding about what's going on. I actually come from the perspective of a provider. My day job is to interact with healthcare providers and injured workers that are part of the system. My experience spans 20 plus years of healthcare and workers' compensation. This is anecdotal as well in terms of what I'm seeing or experiencing, things that have been shared with me from other providers with injured workers across the state, and primarily would deal with non-domestic carriers. . .unfamiliarity with West Virginia compensation rules. So, the majority of the situations that I run into were other providers that come to me and say, "Hey, I have an issue related to non-domestic carriers that are simply unaware that this is the way you conduct business in West Virginia."

There is also an unfamiliarity with the claimants' complaint process, and the timely to fairly act process. There are very few attorneys in the State of West Virginia that do this kind of work anymore. Most of them no longer practice in this arena. Most injured workers [who are injured for the first time] have no knowledge of what to do or where to go. Most providers are too busy to deal with these sort of issues. We want to treat the patient and move forward. So, I think while overall this process is excellent, there may be a little unresponsiveness. It's like my kids. They don't complain very often because after they complain several times I quit listening to them. So, if you're an injured worker out there or you're a healthcare provider out there, you don't know who to complain to or you don't know how to complain, then you quit complaining. Maybe these things quite aren't bubbling up to the surfaces as much as they should.

I don't think at this point it is necessary for us to go back and look at additional regulations and those kind of things. There is a bubbling level of frustration within the general provider and the injured worker relation in terms of some of these things that relate to failure to timely act, failure to pay – I'm not sure where that is on your radar – and failure to pay appropriately for care that is delivered to West Virginia injured workers. So, I just throw that out for consideration or thought to the Council in general. If there is some way of us being able to maybe focus a little bit on those things that would be a service to West Virginia employers, and also West Virginia workers. I thank you for your time here and what you are

doing, but I would ask that we delve perhaps more closely at some point to those two things – the failure to timely act and how that process works.

Judge Roush: Let me just say first and foremost, that process is in our office. That is actually a regulatory function of the agency, so it is technically not a traditional Office of Judges' function that we had original jurisdiction over. Our original jurisdiction is over claims decisions that come down from the carrier, the Old Fund, the self-insured employers. Technically oversight of the failure to timely act process lies in the agency itself. We do that as a hearing examiner for the OIC. So, it is technically within their purview to speak on it. We merely issue a recommended decision. When it first came out I think there was some confusion as to where to put it, and how to actually manage this process. Judge Leach was actually in the office at that time, and this process was kind of a. . .I think Jane Cline was Commissioner at the time. It just kind of formed itself. I'm happy to give you a presentation in conjunction with the agency as to how the process works. The process is in fact entirely within my office, but we do not do it as a part of our original jurisdiction. We do it as a hearing examiner. It is entirely within Judge Alan Drescher's and Judge Kristin Halkias' domain. It does not go through our regular appeals process. Does that make any sense?

Delegate Bates: It does. I think it would be beneficial to hear more about it, and how it works, and also the complaint process. There are two metrics that you're looking at. I'd like to know more about how that process works so that I can educate people that come to me and say, "I've got a problem. What do I need to do about it?"

Mr. Pauley: We have a very general and broad complaint process. Anyone can contact OIC and file a complaint about anything, and we will field it. If we don't have jurisdiction, such as an ERISA complaint or something, we try to get them where they need to go, maybe the U. S. Department of Labor in that particular situation. First of all, there shouldn't be any complexity. Our number is 1-888-TRY-WVIC. You can find it on our website. We handle complaints. We have a special team that handles workers' compensation claims, and those are held every week. We have a high level group that gets together – Assistant Commissioners, Mark is in those meetings, other people are in those meetings, and we review those complaints on a weekly basis. We know what's going on, where it's going. What the public doesn't see is how many issues we resolve without any formal meeting of the complainant to hire counsel, get involved at all. I would say 90% of those we get on top of them right away. It doesn't cost the complainant a dime. We get the carrier, the self-insured employer – whatever the situation is – to respond to us what the problem is. Now there are a few. . .and we'll explain that also to the complainant why we can't help them with a particular situation.

For many years we've been hearing about the non-domestic foreign corporations doing business in the state. All I can tell you is that there are times where the foreign corporations do not spend the time on compliance, but they also make up the vast majority of the orders, market conduct fines, and corrective actions. As Mark mentioned, they are on our website. You can go to our website and look at market conduct under workers' compensation on the ones that we've done. There are some that are confidential, but we have them under corrective action. We've set up benchmarks. We go back and make sure the next year they've met those benchmarks. In fact, we have one or two that did not meet the benchmarks and we continue to review that. On the failure to timely act process, Chief Judge Roush is correct. They sit as our hearing examiner. They make a recommendation to the Commissioner because they do not have fine authority. The Commissioner has the fine authority and the regulatory ability to take action – the analysis, the market conduct.

We try to do outreach. I hear what you're saying. We are here. We can't force people to file complaints. We heard some of that in the third party process years ago. I always said if you don't avail yourself to the process there is not much we can do about it. I can assure you that we address every single complaint that is filed here.

Delegate Bates: I've never had an individual come to me. . .I want to make it clear. . .If there is a concern or issue it is not because of non-response on the part of the Insurance Commissioner or the Office of Judges. It is clearly an issue of unfamiliarity, misunderstanding, communication, and those kind of things that lead to some of these situations where people are hung up in the system and not really sure what to do.

Mr. Pauley: We will take the FTA on a separate track. Let's say a person has a claim that's on their jurisdictional track, but an FTA issue also. They will go ahead and hear that, and make the recommendation. We may move on that, and the claim may still be moving up the track. The FTA is more sort of akin to the Mandamus process. When we were a monopolistic system before 2005 that is how you get the state to act. You file a Mandamus to get them moving if you can't get it resolved. It is still a similar process. I'm not saying that a fine won't result in the end or additional regulatory action. But the key is when someone contacts us and says someone hasn't acted on a claim – from a regulatory standpoint – is to say, "Have you contacted them? Have you acted on this? Have you fixed this problem?" We worry about the fine later. That doesn't mean we don't get to that. We want to make sure they act on the claim as soon as possible.

Delegate Bates: Thank you.

Chairman Dean: Mr. Dissen, do you have any questions?

James Dissen: I don't have any questions. . .maybe a request to get a copy of the slide presentation, and to thank Mr. Hooker for his presentation.

Mr. Hooker: Certainly.

Chairman Dean: We'll have that to you. Not a problem. Mr. Pauley, do you have any questions or comments?

Mr. Pauley: No, sir.

Chairman Dean: Very good. Thank you, sir.

6. **New Business**

Chairman Dean: We'll move onto new business. Does anybody from the Industrial Council have anything under new business they would like to bring up? Mr. Marshall?

Mr. Marshall: No, sir.

Chairman Dean: Mr. Hartsog?

Mr. Hartsog: No.

Chairman Dean: Delegate Westfall?

Delegate Westfall: No, sir.

Chairman Dean: Delegate Bates?

Delegate Bates: No, sir.

Chairman Dean: Mr. Dissen, do you have anything under new business?

Mr. Dissen: No, sir.

Chairman Dean: Mr. Pauley?

Mr. Pauley: No, sir.

7. **Next Meeting**

Chairman Dean: The next meeting will be Thursday, November 10, 2016, at 1:00 p.m. Does that meet everybody's schedule?

8. **Executive Session**

Chairman Dean: The next order of business is the Executive Session. The next item on the agenda is related to self-insured employers. These matters involve discussion as specific confidential information regarding a self-insured employer that would be exempted from disclosure under the West Virginia Freedom of Information Act pursuant to West Virginia Code §23-1-4(b). Therefore it is appropriate that the discussion take place in Executive Session under the provisions of West Virginia Code §6-9A-4. If there is any action taken regarding these specific matters for an employer this will be done upon reconvening of the public session. Is there a motion to go into Executive Session?

Mr. Marshall made the motion to go into Executive Session. The motion was seconded by Mr. Hartsog and passed unanimously.

[The Executive Session began at 2:10 p.m. and ended at 2:29 p.m.]

Chairman Dean: The Resolution is to recommend renewal of self-insured status for the following 11 companies:

Alliance Coal, LLC
Asplundh Tree Expert Company
Ball Metal Food Container LLC
City of Charleston
CONSOL Energy, Inc.
CONSOL Mining Holding Company LLC
CONSOL of Kentucky, Inc.
CONSOL Pennsylvania Coal Company LLC
Fola Coal Company LLC
Murray American Energy, Inc.
Royal Vendors, Inc.

Chairman Dean: Is there a motion to approve the 11 companies for self-insured status?

Mr. Hartsog: So moved.

Mr. Marshall: Second.

Chairman Dean: A motion has been made and seconded to approve self-insured status. Any question on the motion? All in favor, "aye." All opposed? The aye's have it. Motion passed.

9. **Adjourn**

Chairman Dean: Is there anything else that needs to be brought up under the Industrial Council meeting today? I need a motion for adjournment.

Mr. Hartsog made the motion to adjourn the meeting. The motion was seconded by Mr. Marshall and passed unanimously.

There being no further business the meeting adjourned at 2:30.